Correspondence

Female genital mutilation and mental health: how can research help the victims?

In their paper on mental health problems associated with female genital mutilation (FGM) Knipscheer *et al*[1] concluded that 'a considerable minority group, characterised by infibulated women who have a vivid memory of the circumcision and cope with their symptoms in an avoidant way, reports to experience severe consequences of genital circumcision'.

I welcome the authors' brave contribution to this crucial but under-researched topic, and appreciate their attempt at exploring the relationship between FGM and psychopathology in circumcised migrant women. However, despite their genuine acknowledgement of the limitations of their findings, it is my opinion that their paper suffers from various shortcomings which I will try to address here.

The study uses a valid definition of FGM based on a World Health Organization document, and considers the practice a violation of human rights. However, the authors approach the issue with an assumption that FGM is a traumatic event that is likely to lead to symptoms of post-traumatic stress disorder (PTSD) in victims. This assumption is evident throughout the article, especially through their use of the Harvard Trauma Questionnaire in which the item on the list of traumatic events that corresponds most closely to FGM would be 'Sexually abused or raped i.e., forced sexual activity'.[2] To my mind this assumption is based on a Western view of what constitutes a traumatic event and does not take into consideration that such practice, however abhorrent it may seem, could be accepted as normal practice by its own 'victims' and might not be perceived by them as traumatic or as an assault.

PTSD has been seen by many researchers as a Western construct originating from the context of war and shell shock,[3] and it might therefore not have strong validity in individual trauma caused by personal assault. The cross-cultural validity of PTSD has therefore been questioned.[4] However, even if we accept that PTSD is a valid construct in this population and that FGM is a traumatic event likely to give rise to PTSD, it is unsurprising that they found PTSD symptoms given that they actively looked for them. Nonetheless – and despite the small sample of 66 women – they causally link their findings to the experience of FGM. Casting further doubt on this link is that the women sampled might have been through various types of traumatic experiences, including domestic violence and sexual abuse (which are highly associated with FGM[5]) and political and other types of persecution, as well as traumatisation or re-traumatisation during their journey into the Netherlands and their battle to obtain asylum. All these experiences could have contributed to the levels of PTSD symptoms observed in the study and singling out FGM as the main traumatic event is therefore unjustified and unscientific.

The researchers used screening tools to assess the levels of psychological disturbance in their subjects. However, it is well known that screening tools, however validated and culturally adapted, are not diagnostic. Structured clinical interviews remain the gold standard to establish a diagnosis. Despite that, the authors discuss the occurrence of depression, anxiety and PTSD in the study participants as though they were established diagnoses. Moreover, more than half (57%) of the subjects interviewed were 'alone', i.e. single, widowed or divorced. This is likely to have contributed to the high levels of anxiety and depression observed in the study. It is also worth noting that 34% of the subjects had no income which begs the question of whether reporting bias and subjective exaggeration of the psychopathology scores, for reasons such as financial gain, might have affected the results. Finally in this context, political motivation and activism might have also been a source of bias, especially in view of snowball sampling being the recruitment method for the study.

This brings us to the major flaw of the study, which is the lack of a control group. This is unjustified in view of the research question posed here and, in my view, renders the findings of the study rather difficult to interpret. Certainly, from the data presented, it is difficult to arrive at any meaningful conclusions, let alone establish a causal link. A case-control study design is the gold standard to address this kind of research question,[6] and a control group of immigrant women from the same countries as the study group, but without the experience of FGM, could have easily been recruited. Another control group could have been women who were subject to FGM but continue to reside in their country of origin (that is, non-immigrants). A causal link between FGM and psychopathology still cannot be inferred, even using a case-control study.

FGM is an appalling practice that needs the collaboration of individuals, governments and non-governmental organisations if it is to be eradicated. Mental health professionals are expected to take the lead in this fight by providing research evidence that is objective and reliable. It is my belief that this is best achieved by using research studies based on robust methodologies that take into account the cultural context of individuals affected by this practice, and that do not force Western concepts and patronising preconceptions on FGM victims.

Finally, a qualitative research study that lends a voice to the victims of FGM and gives them a chance to tell their story about their true lived experiences might be far more validating of the victims' experiences, and more informative from a research viewpoint, than applying screening tools and carrying out regression analyses.

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Mental Health Officer status and recruitment in psychiatry

Denman *et al*'s paper[1] was thought-provoking and of vital importance given the current difficulties in recruiting to psychiatry training schemes. However, it is our opinion that the authors made a significant omission in not assessing the effect that Mental Health Officer (MHO) status has had on applications to training schemes.

Certain members of staff who were members of the National Health Service pension scheme before 6 March 1995 were eligible for MHO status.[2] This enabled them to take retirement aged 55 with no reduction in pension benefits. MHO status was withdrawn in March 1995.

Financial incentives have become almost a taboo subject, but one which we feel should be revisited. MHO status recognises that, owing to the particular stresses in the specialty, early retirement may be desirable or necessary for some doctors. This offered a significant financial and lifestyle boost to those afforded it.

The crisis in recruitment to psychiatry training posts is well described. It is exacerbated by the effect MHO status has on retention of experienced psychiatrists. Retirement aged 55 – instead of 60 or 65 – only worsens the workforce crisis. The recent reduction in lifetime allowance from £1.25 million to £1 million will make it financially unattractive to those with MHO status to carry on working past 55, even if they wished to do so.

It is highly unlikely that MHO status would ever have been the sole reason to choose psychiatry. However, it formed a significant incentive that directly contributed to the attractiveness of the specialty. It is worth considering what impact its withdrawal is having and comparing the benefits of MHO status to the salary premiums which have been offered in the new junior doctor contracts.

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Authors' reply: psychiatrists' use of formulation

In this issue of the *BJPsych Bulletin* it is heartening to hear discussion and reflection on our work[1] from Professor Hughes,[2] and how particular issues that interested the research team resonated for her.

Professor Hughes brings a perspective from her work in psychotherapy and her own experience of the role of therapy and formulation in psychiatry. She reflects on the range of understandings of formulation within the profession, and possibly the semantic gap between psychology and psychiatry around this. Psychiatrists' understanding of formulation was a key area of interest for the research team, who come from a range of theoretical backgrounds themselves, and from across the psychiatry and psychology divide. This range of enhanced understandings as a result of different ways of formulating is something the team values, and we hope the research provides some further discussion and thinking of psychiatry's relationship with this.

Professor Hughes writes from an interesting generational perspective while acknowledging some distance from the coalface of the National Health Service (NHS). This perspective was interesting for the research team, given our own experiences working as psychologists and consultant psychiatrist in the NHS over the last 15 to 20 years and also through the generational experiences of those being interviewed. In response to her query about the level of experience in the sample, the 12 psychiatrists interviewed had between 7 and 41 years' experience since qualifying, with 8 of them being at consultant level, ranging from early consultant years to people nearing retirement. We would highlight the finding that formulation appeared to be increasingly valued with greater experience and that more experienced interviewees felt more confident in their ability to use formulation.

Staying with the generational theme, Professor Hughes does highlight with some sadness the challenges faced by psychiatrists today. We also felt these were important emerging narratives in the research, particularly increasing workload, time pressures and the loss of thinking space. These were regretted by the psychiatrists interviewed and should act as an alarm to us all. Like Professor Hughes, the research team were saddened to hear some psychiatrists feeling formulation was an add-on role, an addition to the diagnostic, prescribing and risk management roles. We would echo her words in ensuring that supporting psychiatrists in training around recognising the impact of the range of experiences upon mental distress, and building their skills in formulation, should remain a key area of psychiatric training and examination.

However, like Professor Hughes, we remain hopeful for the opportunities of working together across professions and learning from each other for the future.

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